GEORGIA DEPARTMENT OF COMMUNITY HEALTH
DIVISION OF MEDICAL ASSISTANCE

# PRIOR AUTHORIZATION REQUEST*

**CHECK ONE:**

☐ DME ☐ O&P ☐ CASE MGMT.

MAIL COMPLETED FORMS TO:

**GHP**
**P.O. BOX 7000**
**McRAE, GEORGIA 31055**

| 1. Member Name (Last, First, M.I.) | 2. Medicaid ID No. | 3. Nursing Home ☐ Yes ☐ No |
|---|---|---|
| 4. Birthdate | 5. Sex | 6. Address / 7. Telephone (AC/Number) |

| 8. Prescribing Physician/Practitioner Name and Address | 11. Provider of Service(s) Name and Address |
|---|---|
| 9. Provider License Number / 10. Telephone (AC/Number) | 12. Medicaid Provider Number / 13. Telephone (AC/Number) |

| 14. Requested Dates of Service | 15. Description of Service(s) Requested | |
|---|---|---|
| From Thru | 16. Primary Diagnosis Requiring Service(s) | 17. ICD 9-CM |

18. Justification and Circumstances for Required Service(s) (Use separate page if necessary)

STATEMENT OF SERVICE(S):

| | 19. Description of Procedures, Equipment, or Other Services | 20. Procedure Code | 21. Requested or Estimated Price Per Unit | 22. Months or Units of Service Requested | 23. Units per Claim |
|---|---|---|---|---|---|
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**24.** PROVIDER'S SIGNATURE

25. DATE SUBMITTED

** Prior authorization is contingent on patient eligibility and provider's enrollment in the Medicaid Program at the time of service.*

This request is subject to Retrospective Peer Review.

DMA-610 (3/03)